Sports Medicine
& Training Center

Patient Information

Patient Name: _____

Date of Injury: _____

Check the following which apply to your injury:

□ work related injury □ motor vehicle accident □ recurrence of previous injury
□ fall □ athletic / recreational injury □ cause unknown □ surgery
□ OTHER: _____

Have you had any orthopedic surgeries? NO _____ YES _____ If yes, list procedures and dates: _____

_____

_____

Check any of the following medical conditions you have that may interfere with your treatment:

□ No known conditions that will affect treatment
□ Osteoarthritis □ Diabetes Mellitus Type 1
□ Cardiovascular Disease □ Diabetes Mellitus Type 2
□ Allergies (please list) _____
□ Other (please list) _____

Are you currently taking medications, either prescribed or OTC? NO _____ YES ____
If yes, please list: _____

_____

Other than your referring physician, have you been treated by any other medical professional for this injury? NO ____ YES ____
If yes, circle one: physical therapist chiropractor massage other:_____

Type of Pain (circle):
Sharp Dull Ache Tingling Numbness Other:_____

_____

Please list any recreational activities/hobbies that you participate in and how often and for what duration you perform them: _____

_____

_____

Please list goals you would like to achieve during your course of treatment:

_____

_____

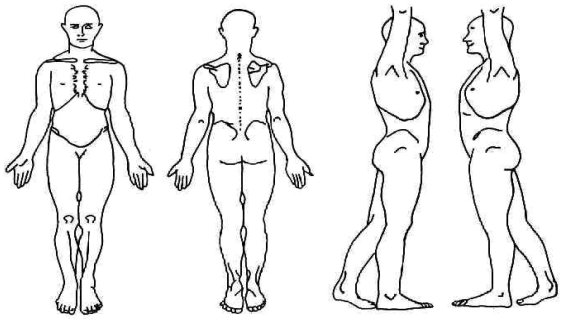
_____

_____

Rate the intensity of the pain

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Please indicate location of symptoms



_____ _____ _____
Signature Relationship to patient Date

Which of the following represents the reason you chose SMTC? (Circle all that apply)

I have been a patient or exercise client here before
A family member, friend or co-worker has been a patient or exercise client before
My physician recommended SMTC My school trainer recommended SMTC School: _____
Case manager Attorney recommended SMTC Workers' Compensation
Online What Site: _____ Drive by/Live Close By Insurance Plan Website
I have participated in dance activities at the SMTC studio or was attracted by the Dance Medicine Program
I was a participant or spectator at an athletic event where SMTC was providing medical services
Other: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial:_____

Street Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____/_____/_____ SSN: _____/_____/_____

Home Phone: _____ Alternate/cell phone: _____

Sex: Male Female Marital Status (circle one): Single Married Domestic Partnership Widowed

Occupation or School: _____ Full-Time Part-Time

Duty Level: Full Light Other _____ Out of Work Since: _____ Return to Work: _____

Emergency Contact Name: _____

Relationship to Patient: _____ Phone Number: _____

May we contact you via email with company updates, patient surveys and/or company newsletters?

YES ____ NO____ Email Address: _____

INSURANCE AND GUARANTOR INFORMATION

Policy Holder: _____ Date of Birth: _____/_____/_____ SSN: _____/____/____

Relationship to patient: (circle one) Self Spouse Parent/Guardian

Secondary Insurance Policy Holder: _____ Date of Birth: _____/_____/_____

Relationship to patient: (circle one) Self Spouse Parent/Guardian

Who should be billed for any balance due (after insurance)?: _____

Is guarantor's address different than patient?: YES____ NO____ If yes, please provide below:

_____

LEGAL INFORMATION

Is this a Worker's Compensation case?: NO ____ YES ____ Company: _____

Contact/Case Manager: _____ Phone Number: _____

Employer: _____

Employer Street Address: _____ City: _____

State: _____ Zip Code: _____ Employer Phone Number: _____

Is this a Litigation case?: NO ___ YES ___ Attorney's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Attorney Phone Number: _____ Contact Person: _____

Is this an auto accident?: NO ____ YES _____ Claim# _____

Adjuster's Name: _____ Adjuster's Phone Number: _____

I acknowledge that the information I have provided is true and correct and I am ultimately responsible for payment of all charges incurred for my therapy. If my insurance benefits or any settlement received from litigation is not sufficient to pay for these services, then I personally guarantee payment. I authorize my insurance carrier to make any payment for services rendered to me or my dependent directly to the provider. Any account balance remaining unpaid over six months will be charged a 1.5% service fee unless automatic payment plan is established. Any account remaining unpaid without satisfactory arrangements may be turned over to a collection agency. Should my account be referred to an agency for collection, I agree to pay reasonable collection costs on the unpaid balance. I hereby authorize The Sports Medicine and Training Center, L.L.C. to render treatment to me as ordered by my physician and grant permission to The Sports Medicine and Training Center, L.L.C. to obtain my medical records from my physician. I also authorize The Sports Medicine and Training Center, L.L.C. to release my medical records to my insurance carrier / worker's compensation carrier / third party guarantor as needed to collect payment.

_____ _____ _____

Signature Relationship to patient Date